Department of Health
Office of Emergency Medical & Trauma Prevention

OUT-OF-STATE APPLICATION

Social Security Number
(Required under 42 USC 666 and Chapter 26.23 RCW)

Date of Birth
(mm/dd/yyyy)

Phone Number

Last Name

First Name

M.I.

Address
(Where you want your certification card to be sent)

City, State, Zip Code

THE CERTIFICATION LEVEL I AM APPLYING FOR IS: *(Please Select One)*

Part 'A'

☐ First Responder ☐ EMT ☐ IV Tech ☐ Airway Tech ☐ IV/Airway Tech ☐ ILS Tech ☐ ILS W/Airway ☐ Paramedic

Will you be *primarily* a "paid" or "volunteer" EMS provider? ☐ PAID ☐ VOLUNTEER

CERTIFICATION REQUIREMENTS:

Part 'B'

	YES	NO
1. Have you submitted a course completion document or letter from the training agency to the DOH, OEMTP *Licensing and Certification Section*?	☐	☐
2. Have you submitted the signed Washington State Specific Objectives Affirmation Statement for the level of certification you are seeking?	☐	☐
3. Have you submitted a certificate of completion for the Washington State *"Infectious Disease Prevention for EMS Providers"* training (Revised October 1997)?	☐	☐
4. Have you attached a legible copy of your *current* state or NREMT certification card?	☐	☐
5. Have you attached a legible copy of a *current* official picture identification card which also shows your date of birth (i.e., driver's license, passport, military ID, etc.)?	☐	☐
6. Are you a high school graduate or have you earned a GED certificate?	☐	☐

EMS AGENCY ASSOCIATION REQUIREMENT:

Part 'C'

EMS AGENCY NAME:

Name: _____

Address: _____

Phone Number: _____

EMS Contact Person: _____

DOH Agency License Number: _____

DO NOT DUPLICATE

Part 'C'
(Continued)

If you are certified, will you continue to provide EMS care with the agency you identified on the front of your application? YES ☐ NO ☐

EMS AGENCY SUPERVISOR:

"I affirm that if this applicant is certified, he/she will provide care with our EMS agency."

Name of EMS Agency Supervisor **(Please Print)** | **Original Signature** | **Date**

MEDICAL PROGRAM DIRECTOR:

The signature of the Washington State Medical Program Director (MPD) for the county where the applicant is providing care, or where his/her EMS agency is based, is *required* before state certification may be granted to this applicant.

☐ "I ***recommend*** certification ☐ I ***do not recommend*** certification *(attach a memo for details)*

of this applicant based on the statements above, pending successful completion of the required examinations and/or evaluations. This applicant, if recommended for certification, has a copy of my county protocols."

MPD's Original Signature | **Date**

APPLICANT:

"I hereby affirm and declare that the information provided on this application is *true* and *correct*, and that any fraudulent entry may be considered sufficient cause for *rejection* or subsequent *revocation* of my certification. I further affirm that I have received a copy of the MPD's *protocols* for my level of certification."

Applicant's Original Signature | **Date**

RETURN COMPLETED APPLICATIONS TO:

Western Washington

Office of Emergency Medical & Trauma Prevention
Licensing and Certification Section
PO Box 47853
Olympia, WA 98504-7853
1-800-458-5281, Ext. #1

Eastern Washington

Office of Emergency Medical & Trauma Prevention
Licensing and Certification Section
1500 West 4th, Suite #403
Spokane, WA 99204
1-800-458-5276

Office of Emergency Medical and Trauma Prevention website: www.doh.wa.gov/hsqa/emtp/

OUT-OF-STATE APPLICATION

Washington State Emergency Medical and Trauma Prevention

Part 'D' - Personal Information

C O N F I D E N T I A L

Certification of health care professionals is designed to protect the citizens of Washington State from unsafe health care. As part of the certification process, <u>all</u> applicants for certification are required to answer the same, legally defensible, personal data questions, narrowly focused to the fitness to practice the essential skills of this profession.

Part 'D' must be completed by all applicants and returned *directly* to the Department of Health to maintain confidentiality. Please follow the instructions below:

1. **Detach and review this portion of the application. Make sure you have provided *complete* and *accurate* information.**
2. **Return <u>only</u> Part D of the application in the enclosed envelope. Please include all information required below.**

LAST NAME | **FIRST NAME** | **M.I.**

ADDRESS | **CITY, STATE, ZIP CODE**

SOCIAL SECURITY NUMBER
(Required under 42 USC 666 and Chapter 26.23 RCW)

COUNTY OF *PRIMARY* EMPLOYMENT

	Yes	No
1. Do you **currently** have a medical condition which **in any way impairs or limits your ability to provide EMS with reasonable skill and safety**? If *"yes",* please explain.	☐	☐

"Currently" means recently enough so that your medical condition may have an ongoing impact on your ability to function as an EMS provider, and includes at least the past two years.

"Medical condition" includes physiological, mental or psychological conditions or disorders such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered *"yes"* to question #1, please explain if, and how, the limitations or impairments caused by your medical condition are *reduced* or *eliminated* because you receive ongoing treatment. (Are you using medication to treat this condition? If so, please list).

1b. If you answered *"yes"* to question #1, please explain if, and how, the limitations or impairments caused by your medical condition are *reduced* or *eliminated* because of your field of practice, the setting, or the manner in which you have chosen to practice.

If you answered *"yes*" to question #1, the Department will make an assessment of the nature, severity, and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" to determine if you are eligible for certification and whether conditions should be imposed.

2. Do you **currently** use chemical substance(s) in any way which impairs or limits your ability to provide EMS with reasonable skill and safety? If *"yes",* please explain.	☐	☐

"Currently" means recently enough so that the use of chemical substance(s) may have an ongoing impact on one's functioning as a certified EMS provider, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, in addition to those taken by way of a valid prescription for legitimate medical purposes in accordance with the prescriber's direction.

3. Are you **currently** engaged in the *illegal use* of controlled substances?	☐	☐

"Currently" means recently enough so that the use of controlled substances may have an ongoing impact on your ability to function as a certified EMS provider, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances not taken in accordance with the directions of a licensed healthcare practitioner.

OUT-OF-STATE APPLICATION (continued)

	Yes	No
4. Have you ever been diagnosed as having, or have you ever been treated for: Pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☐

"Pedophilia" means: An unnatural desire for sexual relations with children.

"Exhibitionism" means: An abnormal impulse that causes one to expose the genitals to one of the opposite sex.

"Frotteurism" means: Recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving touching and rubbing against a non-consenting person.

"Voyeurism" means: Deriving sexual pleasure from observing the sexual activity of others.

If you must answer *"yes"* to any of the remaining questions, provide an explanation and copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, no contest (nolo contendre) or a plea of similar effect, or had prosecution or sentence deferred or suspended in connection with:		
a. The use or distribution of controlled substances or legend drugs?	☐	☐
b. A charge of a sex offense?	☐	☐
c. Any other crime other than *minor* traffic infractions? (For example: Driving While Intoxicated (DWI), Driving Under the Influence (DUI), and Reckless Driving).	☐	☐
6. Have you ever been found in any civil, administrative, or criminal proceeding to have:		
a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☐
b. Committed any act involving moral turpitude, dishonesty or corruption?	☐	☐
c. Violated any state or federal law or rule regarding the practice of a health care profession? If *"yes",* explain and provide copies of all judgments.	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If *"yes",* explain and provide copies of all judgments, decisions and agreements.	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended or restricted by a state, federal or foreign authority? Have you ever surrendered such credential to avoid, or in connection with, an action by such authority?	☐	☐
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?	☐	☐
10. Have you previously provided the Department of Health with information regarding any *"yes"* answers?	☐	☐

PLEASE NOTE: If you have answered *"yes*" to any of the above questions, you must submit a brief written statement and all relevant documents with this portion of the application,. Please do not *re-send* documents which you have previously provided to this office to explain any "yes" answers.

APPLICANT STATEMENT: (This portion must be signed by the applicant)

"I hereby affirm and declare that the above information is true and correct, and that any fraudulent entry may be considered sufficient cause for rejection or subsequent revocation of my certification."

Applicant's original signature only _____ **Date** _____

Phone # _____

WESTERN WASHINGTON: Department of Health, *Office of Emergency Medical & Trauma Prevention*, P.O. Box 47853, Olympia WA 98504-7853
EASTERN WASHINGTON: Department of Health, *Office of Emergency Medical & Trauma Prevention,* 1500 West 4th, Suite 403, Spokane WA 99204

D O NOT D U P L I C A T E

Office of Emergency Medical And Trauma Prevention
Licensing and Certification Section
Post Office Box 47853
Olympia WA 98504-7853
(360) 705-6711

Confirmation Form

PAGE 1 OF THIS CONFIRMATION FORM MUST BE COMPLETED BY APPLICANT.
APPLICANT MUST SIGN THIS FORM IN THE PRESENCE OF A NOTARY PUBLIC.

Please make copies if necessary, and complete the top portion (*please print*) and send to all state(s) and the National Registry of EMTs (if you are certified with the National Registry) for all current EMS certifications or licenses held. Please note that some states may charge a fee to complete this form.

AUTHORIZATION TO RELEASE INFORMATION TO THE WASHINGTON STATE OFFICE OF EMERGENCY MEDICAL AND TRAUMA PREVENTION

NAME: _____
(Last Name) (First Name) (MI)

ALSO KNOWN AS: _____

MAILING ADDRESS: _____
(City) (State, Zip)

STREET ADDRESS: _____
(City) (State, Zip)

I hereby authorize _____ EMS Agency to furnish the information on Page 2 of this document.
(state to which you are sending this form)

Certification/License Number: _____ **EMS Level/Type:** _____

Social Security Number: _____ **Date of Birth:** ___/___/___
(Required under 42 USC 666 and Chapter 26.23 RCW) (mm/dd/yyyy)

Notary Public Seal

_____
*Applicant to sign in presence of Notary Public

Subscribed and sworn to before me this _____ day of _____, 20___.

Notary Public for _____ *My Commission Expires* ___/___/___

OVER

_____
Notary Signature

THIS SECTION TO BE COMPLETED BY STATE
(OR NATIONAL REGISTRY OF EMTs) OF CERTIFICATION OR LICENSURE

Please complete the form below, and return in a sealed envelope (*marked with a state seal across the envelope flap*), to the applicant listed on page 1.

1. Applicant received certification/license by:

Exam Yes ☐ No ☐ Reciprocity granted on certification from

_____
(State, National Registry)

2. State of certification/license:

Active ☐ Expiration Date:____/____/____

Inactive ☐

3. Certification/License issued on:____/____/____ Certification/License No:_____

Was the course for this EMS level taught in your state? Yes ☐ No ☐

Dates of Course: Beginning____/____/____ Completion____/____/____

Do the EMS courses in your state meet or exceed the Department of Transportation National Standard Curriculum for the level requested?

Yes ☐ No ☐

Basic ☐ Intermediate ☐ Paramedic ☐ Other ☐

If other, please explain

_____

4. Has this person ever been disciplined, been placed on probation or had their certification/license suspended, revoked or denied by your agency, or by the supervising physician?

Yes ☐ No ☐

I hereby certify that the above is true and correct as recorded in the files of this office.

Signature Name (print)

Title Date

State seal

WESTERN WASHINGTON: Department of Health, ***Office of Emergency Medical & Trauma Prevention***, P.O. Box 47853, Olympia WA 98504-7853
EASTERN WASHINGTON: Department of Health, ***Office of Emergency Medical & Trauma Prevention,*** 1500 West 4th, Suite 403, Spokane WA 99204
Office of Emergency Medical and Trauma Prevention website: ***www.doh.wa.gov/hsqa/emtp/***

(01/03) [Supersedes all previous forms]